



# KAYDOKTE HEALTH ORGANIZATION

**AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**  
PLEASE SEND A COPY OF THIS RELEASE WITH THE REQUESTED RECORDS  
**PATIENT INFORMATION**

Name:

DATE OF BIRTH:

Social Security:

ADDRESS:

CITY:

ZIP CODE:

PHONE:

**RELEASE FROM**

I AUTHORIZE RELEASE OF MEDICAL RECORDS FROM  
PHYSICIAN / FACILITY:

ADDRESS:

CITY:

ZIP CODE:

PHONE #:

FAX #:

**RELEASE TO**

Kaydokte Health Organization  
Address/Phone/Fax

**RELEASE INFORMATION**

REASON:  CHANGE OF INSURANCE  MOVING OUT OF AREA  PERSONAL  
FILE  TRANSFER OF PHYSICIAN  SPECIALIST CONSULTATION  LEGAL

**PLEASE RELEASE THE FOLLOWING (CHECK ALL THAT APPLIES)**

RECENT H&P  LAB REPORT  HOSPITAL REPORTS  LAST 3 VISITS  X-  
RAY REPORT  OTHER

PLEASE ALLOW (7) DAYS FOR PROCESING. INCOMPLETE INFORMATION WILL DELAY  
PROCESSING' USE OF THIS INFORMATION FOR ANY  
OTHER THAN THE STATED PURPOSE IS PROHIBITED. THIS INFORMATION IS FOR THE USE OF THE  
DESIGNATED RECIPIENT ONLY AND CANNOT  
BE PROVIDED TO ANY OTHER AGENCY

**CONSENT**

I AUTHORIZE THE RELEASE OF ALL INFORMATION INDICATED, AND IF I AM AWARE THAT THE  
RECORDS RELEASED MAY CONTAIN INFORMATION  
RELATING TO, PSYCHIATRIC, PSYCHOLOGICAL TESTING, PHYSICAL ABUSE OR DRUGS AND  
ALCOHOL ABUSE'

I AUTHORIZE THE RELEASE OF HIV/AIDS TEST RESULTS\_ YES-NO  — YOUR INITIALS

I UNDERSTAND THAT I MAY BE CHARGED FOR COPIES PROVIDED.

(PLEASE CIRCLE) PATIENT, PARENT, GUARDIAN, CONSERVATOR, OR PATIENT REPRESENTATIVE

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



# KAYDOKTE

HEALTH ORGANIZATION

WITNESSED BY DATE \_\_\_\_\_

DATE \_\_\_\_\_